

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**Medicare Payments for Septicemia**



**JUNE GIBBS BROWN  
Inspector General**

**MARCH 1999  
OEI-03-98-00370**

## **OFFICE OF INSPECTOR GENERAL**

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# EXECUTIVE SUMMARY

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## PURPOSE

To identify hospitals with atypically high billing patterns for patients with septicemia (DRG 416).

## BACKGROUND

Under Medicare's PPS reimbursement formula, the payment a hospital receives is based upon the individual hospital's payment rate and the weight of the DRG to which a case is assigned. A DRG's weight represents the average resources needed for cases in that classification relative to the average resources needed for cases in all DRGs. The higher the relative weight, the greater the reimbursement.

DRG 416 represents septicemia (blood poisoning). Generally, the DRG payment for septicemia is dependent on the principal diagnosis code. Twenty-four diagnosis codes can result in a discharge grouping of DRG 416. This code typically triggers a higher Medicare reimbursement compared to other diagnostic codes with similar symptoms. DRG 320, kidney and urinary tract infections, is one such code.

The Health Care Financing Administration (HCFA) contracts with two Clinical Data Abstraction Centers to collect clinical data from hospital medical records. A part of the Abstraction Center's responsibility is the validation of a national random sample of claims from all Medicare inpatient hospital discharges. The results of the 1996 validation effort showed that approximately 13 percent of the sample DRG 416 discharges should have been coded to a lower weighted DRG. HCFA estimated that the total overpayment attributable to incorrect DRG 416 classifications was \$48,930,882.

Our office recently conducted DRG validation work on a sample of 2,622 Medicare inpatient hospital discharges from 1996. The results of this validation showed that approximately 20 percent of the sample DRG 416 discharges were improperly coded.

We analyzed the Medicare Provider Analysis and Review file, for fiscal years 1993 to 1996, to identify hospitals with atypically high billings for DRG 416.

## FINDINGS

*A small number of hospitals have atypically high Medicare billings for DRG 416.*

A relatively small number of hospitals had abnormally high DRG 416 discharges compared to national figures. For 120 hospitals (out of 4,701) identified in our review, DRG 416 discharges increased from 4,583 in 1993 to 13,450 in 1996 -- an almost three-fold increase. Nationally, DRG 416 discharges increased from 167,900 in 1993 to 220,441 in 1996.

The proportion of DRG 416 discharges to total discharges increased by a factor of almost 3, from 1.57 percent in 1993 to 4.33 percent in 1996. Nationally, this same proportion increased from 1.51 percent in 1993 to 1.88 percent in 1996.

Previous DRG validation reviews showed that a substantial number of improperly coded DRG 416 discharges should have been coded as DRG 320. For the 120 hospitals, DRG 320 discharges decreased from 6,330 in 1993 to 4,792 in 1996. Nationally, DRG 320 discharges increased from 172,659 in 1993 to 177,042 in 1996.

***The inappropriate billing of DRG 416 could have a major financial impact.***

From the previous DRG validation work performed by our office, we found an average per discharge difference of \$2,254 between DRG 416 and the DRG we believe should have been coded. For the 120 hospitals, the number of DRG 416 discharges exceeded national norms by approximately 7,345 cases. Using the \$2,254 per discharge difference from our previous work, we estimate that potential overpayments could be as high as \$16.6 million.

The true upcoding error rate can only be determined by undertaking a detailed claims review at each hospital. Therefore, the potential overpayments at each hospital will vary according to applicable coding error rates.

**RECOMMENDATION**

We recommend that HCFA institute a system to identify hospitals with atypically high billings for DRGs identified by the Clinical Data Abstraction Centers as having a high potential for being upcoded. Once the hospitals have been identified, a review of the discharges should be made.

We have referred the 120 hospitals that we have identified as having atypically high growth in DRG 416 discharges to our Office of Investigations.

**AGENCY COMMENTS**

The HCFA concurred with our recommendation. The HCFA stated that under the Peer Review Organization (PRO) contracts that will take effect between August 1999 and February 2000, PROs will conduct a Payment Error Prevention Program for inpatient hospital care. Under this approach, HCFA will conduct an independent ongoing surveillance of inpatient payment error rates, both nationally and on a state-by-state basis. The HCFA will also conduct analyses of discharge patterns and provide the results to the PROs. The PROs will conduct additional analyses of discharge patterns and take steps to reduce or eliminate erroneous billing. The full text of HCFA's comments is provided in Appendix C.

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# INTRODUCTION

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## PURPOSE

To identify hospitals with atypically high billing patterns for patients with septicemia (DRG 416).

## BACKGROUND

In 1983, the Congress enacted a PPS, under which Medicare pays a fixed, predetermined amount for inpatient hospital services for each patient. Payment for a case is determined by taking a hospital's individually determined base payment rate and multiplying it by the weight of the DRG to which the case is assigned. A DRG's weight represents the average resources needed for cases in that classification relative to the average resources needed for cases in all DRGs. Certain hospitals, such as psychiatric and long-term, are excluded from the PPS system.

### *Claims Processing*

Cases are classified into DRGs for payment under the PPS based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. Hospitals use codes from the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) to report diagnosis and procedure information. (HCFA Final Rule, Federal Register, August 30, 1996)

When a patient is discharged, the physician will summarize information on a discharge face sheet which includes the principal diagnosis, defined as the condition which caused the patient's admission, secondary or coexisting diagnoses, and procedures. A coder, trained in medical classification, will use the information to assign the most appropriate ICD-9-CM code. The hospital coder will review the entire medical record as part of the coding process.

A hospital receives payment for treating a Medicare patient by preparing a claim and forwarding it to the Medicare fiscal intermediary. The intermediary enters the information into its claims system and puts it through a series of automated screens. These screens, called the Medicare Code Editor, identify cases that need further review before being classified into a DRG.

Cases are classified by the GROUPER software program into the appropriate DRG. This program classifies each case into a DRG based on diagnosis, procedure code, and demographic information. It is used both to classify current cases in order to determine payment and to classify past cases for purposes of measuring relative hospital resource consumption. The Medicare Provider Analysis and Review File contains all records for Medicare hospital inpatient discharges. The data in this file are used to adjust the DRG weights and to assess possible DRG classification changes.

Hospital reimbursement is calculated by multiplying the "relative weight" of each DRG category by a standardized amount, as modified by certain hospital-specific factors. Reimbursement will

increase as the relative weight increases. Significant financial implications can result from hospital mis-assignment of the ICD-9-CM categories or erroneous assignment of patient diagnoses.

### ***DRG 416***

The hospital stays of patients over the age of 17 whose principal diagnosis relates to septicemia, are coded as DRG 416. DRG 416 contains the ICD-9-CM codes indicating septicemias such as streptococcal septicemia, anaerobic septicemia, and pseudomonas septicemia. There are 24 ICD-9-CM codes that can lead to a coding of DRG 416.

Septicemia (blood poisoning) can result from bacteria infecting the bloodstream in various ways. It is a very serious infection which can rapidly lead to septic shock and death. Symptoms of septicemia include fever, chills, and nausea.

### ***DRG 320***

DRG 320, kidney and urinary tract infections, will result from any one of 67 principal diagnoses. These diagnoses include conditions such as urinary tract infection (not otherwise specified) and pyeloureteritis cystica.

DRG 320 is an example of a code to which DRG 416 can be mis-classified. It can have symptoms similar to DRG 416, however, diagnostic testing through a urine analysis or culture should differentiate the two codes.

The mis-classification of DRG 320 to DRG 416 can have significant financial implications. The 1996 relative weight of DRG 416 is 1.4770 whereas the relative weight of DRG 320 is .9320. Therefore, mis-classifying a DRG 320 discharge as DRG 416 will result in an overpayment of approximately \$2,000 per discharge.

### **DRG Validation Efforts**

#### **HCFA**

Through the Medicare Peer Review Organizations (PROs), HCFA contracts with two Clinical Data Abstraction Centers to collect clinical data from hospital medical records. The PROs use this data in carrying out clinical quality improvement projects.

The PROs are groups of practicing physicians and other health care professionals contracted by HCFA to oversee the care given to Medicare patients. They are located in each State and US territory and decide whether care given to Medicare patients is reasonable, necessary, and provided in the most appropriate setting. Each PRO is required to subcontract with the Abstraction Centers for DRG validation work.

A part of the Abstraction Center's responsibility is DRG validation. The 1996 validation effort consisted of a nationally representative random sample of 20,152 claims from all Medicare

inpatient hospital discharges. There were 369 DRG 416 discharges in the sample. The sample results disclosed that approximately 14 percent (53) of the sample DRG 416 discharges were improperly coded. Most (49 out of 53) of the erroneously coded discharges resulted in overpayments to hospitals. The total estimated overpayment attributable to DRG 416 discharges for 1996 was \$48,930,882.

The 49 discharges resulting in overpayments to the facility were found to belong to 20 other DRGs. The most prevalent was DRG 320 which accounted for 20 of the upcoded discharges (41 percent). The next most prevalent were DRG 089 (Simple Pneumonia & Pleurisy Age > 17 W CC [with complications and comorbidities]) at 8 percent and DRG 296 (Nutritional and Misc. Metabolic Disorders Age > 17 W CC) at 6 percent. A complete listing of the appropriate DRG codes can be found in Appendix A.

The Abstraction Centers' validation effort provides HCFA with an overall assessment of DRG coding and identifies potential problem DRGs. However, a thorough analysis of the more problematic DRGs at the level of individual hospitals is not done.

### **Office of Inspector General (OIG)**

Our office, in a study entitled, *Using Software to Detect Upcoding of Hospital Bills* (OEI-01-97-00010, August 1998), performed DRG validation work on a sample of 2,622 Medicare inpatient hospital discharges. Eighty-four of 2,622 sample discharges were for DRG 416. The results of this validation showed that approximately 20 percent (17) of the sample DRG 416 discharges were improperly coded. All 17 erroneously coded discharges resulted in overpayments to the hospitals.

The erroneously coded DRG 416 discharges should have been coded to 12 other DRGs. Twenty-four percent (4 of 17) of the erroneously coded discharges should have been coded to DRG 320. DRG 089 (Simple Pneumonia & Pleurisy Age > 17 W CC) and DRG 182 (Esophagitis, Gastroent & Misc. Digest Disorders Age > 17 W CC) were next at 12 percent each. A complete listing of the appropriate DRG codes can be found in Appendix B.

A comparison of the tables in Appendices A and B show that seven of the DRGs are in both tables (these DRGs are bolded in each table). These seven DRGs account for 69 percent of the erroneous records in HCFA's Abstraction Centers data and 66 percent of the erroneous records in the OIG's data.

### **METHODOLOGY**

We used data from the Medicare Provider Analysis and Review (MedPAR) file to identify the number of discharges in DRG 416 for fiscal years 1993 to 1996. We determined the increase in the proportion of DRG 416 discharges to total discharges from 1993 to 1996 nationally and for each hospital identified in the MedPAR file.

We then identified those hospitals where more than 3 percent of their discharges were due to DRG 416 and the proportion of DRG 416 discharges to total discharges increased more than 100



percent from 1993 to 1996. From these hospitals, we selected those with 50 or more discharges in DRG 416 in 1996. We excluded those hospitals currently under investigation by the OIG.

For the hospitals selected, we compiled a table of DRG 416 and DRG 320 discharges from 1993 to 1996. We used this information to determine the billing patterns for DRG 416 and DRG 320 discharges over the four year period. We also used this information to look at DRG 416 increases, at each hospital, both from 1993 to 1996 and from year to year within that time period.

To calculate the amount of the potential overpayment of DRG 416 in the identified hospitals, we first determined the national adjusted operating standardized amount by adding the labor and non-labor columns in table 1A of the September 1, 1995 Federal Register. Using this standardized amount as a basis, we determined monetary differences between the billed and appropriate DRG from results of our validation work. We calculated potential overpayments by multiplying the applicable differences by estimates of total erroneous claims.

This inspection was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

# FINDINGS

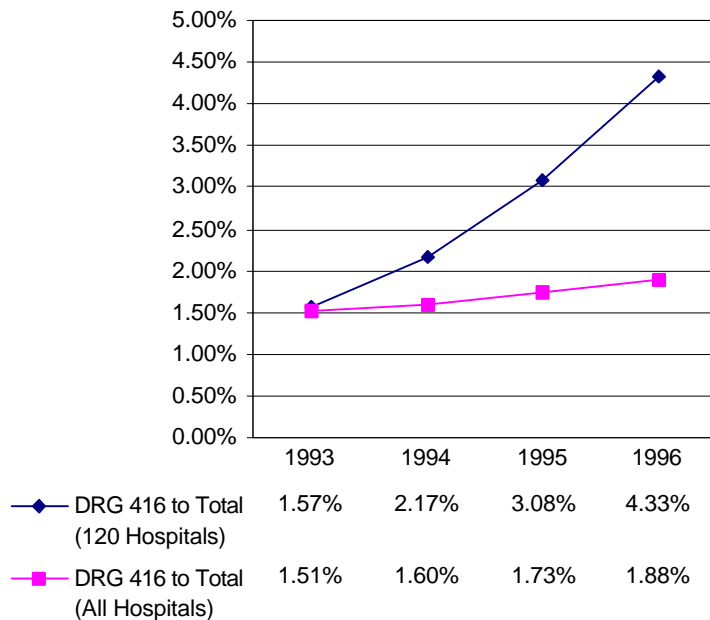
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## A SMALL NUMBER OF HOSPITALS HAVE ATYPICALLY HIGH MEDICARE BILLINGS FOR DRG 416.

A relatively small number of hospitals had abnormally high DRG 416 discharges compared to national figures. For 120 hospitals (out of 4,701), that met our selection criteria as stated in the methodology, DRG 416 discharges increased by a factor of almost 3, from 4,583 in 1993 to 13,450 in 1996. This represents an average increase of 43 percent a year. Nationally, DRG 416 discharges increased from 167,900 in 1993 to 220,441 in 1996, with an average increase of 9 percent a year.

This atypical pattern is also shown by the significant difference in proportions of DRG 416 discharges to total discharges between the 120 hospitals and all hospitals. As illustrated in the chart below, for the 120 hospitals, the proportion of DRG 416 discharges to total discharges increased from 1.57 percent in 1993 to 4.33 percent in 1996. This represents an almost three-fold increase, with an average increase of 40 percent a year. For all hospitals, this same proportion increased from 1.51 percent in 1993 to 1.88 percent in 1996, with an average increase of 8 percent a year.

**Proportion of DRG 416 Discharges to Total Discharges  
1993 to 1996**



For the 120 hospitals, the proportion of 1996 DRG 416 discharges to total discharges increased by a factor ranging from 2 to 19 times 1993 figures. Specifically, for eight hospitals, the proportion of DRG 416 discharges to total discharges increased by a factor of more than six. In 26 hospitals, this proportion increased by a factor ranging between 4 and 6. And in the remaining 86 hospitals, this proportion increased by a factor of 2 to 3 times 1993 numbers.

There were some hospitals that exhibited unusually high increases in DRG 416 discharges from 1993 to 1996. For instance, one hospital's DRG 416 discharges increased from 13 (out of 989 total discharges) in 1993 to 113 (out of 1,324 total discharges) in 1996 -- an almost nine-fold increase. Another hospital's DRG 416 discharges increased from 31 (out of 1,802 total discharges) in 1993 to 113 (out of 1,921 total discharges) in 1994 -- an almost four-fold increase.

The 120 hospitals are located in 30 States. Of the 120 hospitals, 61 are concentrated in 6 States. California is the top State with 15 hospitals, Texas is next with 14, and Georgia is third with 12. The remaining States contain hospitals numbering in the range from one to seven.

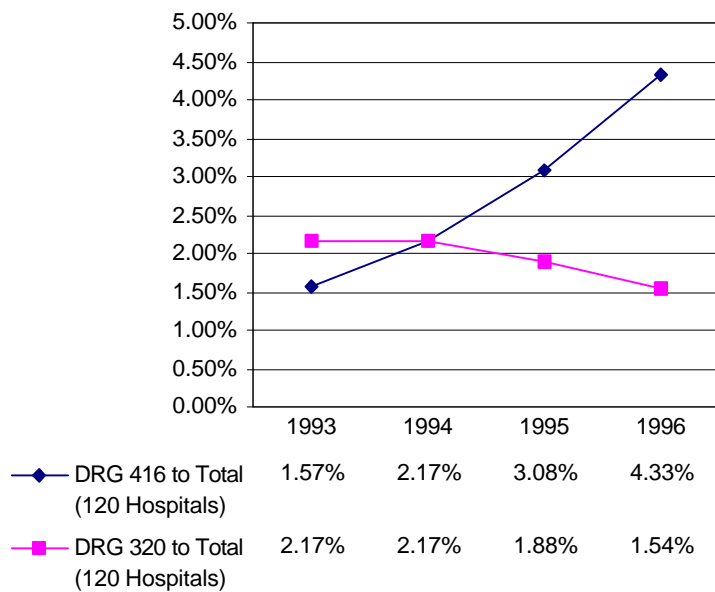
DRG validation reviews previously conducted showed that a substantial number of the improperly coded DRG 416 discharges should have been coded to DRG 320. For the 120 hospitals, DRG 320 discharges decreased from 6,330 in 1993 to 4,792 in 1996. Nationally, DRG 320 discharges increased from 172,659 in 1993 to 177,042 in 1996. The chart below illustrates the billing pattern of increasing DRG 416 discharges and decreasing DRG 320 discharges for the 120 hospitals, from 1993 to 1996.

**THE QUESTIONABLE BILLING OF DRG 416 COULD HAVE A MAJOR FINANCIAL IMPACT.**

From the previous DRG validation work performed by our office, we found an average per discharge difference of \$2,254 between DRG 416 and the DRG we believe should have been coded. For the 120 hospitals, the number of DRG 416 discharges exceeded national norms by approximately 7,345 cases. Using the \$2,254 per discharge difference from our previous work, we estimate that potential overpayments could be as high as \$16.6 million.

The true upcoding error rate can only be determined by undertaking a detailed claims review at each hospital. Therefore, the potential overpayments at each hospital will vary according to applicable coding error rates.

**Proportion of DRG 416 and DRG 320 Discharges to Total Discharges 1993 to 1996**



# RECOMMENDATION

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We recommend that HCFA institute a system to identify hospitals with atypically high billings for DRGs identified by the Clinical Data Abstraction Centers as having a high potential for being upcoded.

At the present time, HCFA uses the results of the Abstraction Centers DRG validation efforts to monitor the Prospective Payment System nationwide. Although the results have not been published, we believe the information contained in this effort can be of great help to HCFA staff. An analysis of this information can point out which DRGs have a high potential for upcoding.

The next step would be to follow an analysis such as we have presented here. By reviewing the coding patterns of the individual hospitals over time, HCFA could identify facilities that may have a high potential for upcoding. It is of course understood that only a record review by trained professionals will be able to determine if upcoding has, in fact, occurred. The method we are suggesting here provides a technique to effectively focus the limited resources that HCFA can bring to bear on the problem.

We have referred the 120 hospitals that we have identified as having atypically high growth in DRG 416 discharges to our Office of Investigations.

## AGENCY COMMENTS

The HCFA concurred with our recommendation. The HCFA stated that under the Peer Review Organization (PRO) contracts that will take effect between August 1999 and February 2000, PROs will conduct a Payment Error Prevention Program for inpatient hospital care. Under this approach, HCFA will conduct an independent ongoing surveillance of inpatient payment error rates, both nationally and on a state-by-state basis. The HCFA will also conduct analyses of discharge patterns and provide the results to the PROs. The PROs will conduct additional analyses of discharge patterns and take steps to reduce or eliminate erroneous billing. The full text of HCFA's comments is provided in Appendix C.

# APPENDIX A

## CLINICAL DATA ABSTRACTION CENTERS' 1996 VALIDATION WORK FOR DRG 416

This table shows the appropriate diagnosis related groups (DRGs) for 49 upcoded DRG 416 discharges. The upcoding was found by the 1996 Clinical Data Abstraction Centers' DRG validation work for DRG 416 (Septicemia Age > 17).

Hospital DRG	DRG Weight	Description	Upcoding Frequency	Percent of Total <sup>1</sup>
<b>320</b>	<b>0.9320</b>	<b>Kidney &amp; Urinary Tract Infections Age &gt; 17 W CC <sup>2</sup></b>	<b>20</b>	<b>41%</b>
<b>089</b>	<b>1.1211</b>	<b>Simple Pneumonia &amp; Pleurisy Age &gt; 17 W CC</b>	<b>4</b>	<b>8%</b>
<b>296</b>	<b>0.9166</b>	<b>Nutritional &amp; Misc. Metabolic Disorders Age &gt; 17 W CC</b>	<b>3</b>	<b>6%</b>
144	1.0689	Other Circulatory System Diagnoses W CC	2	4%
<b>207</b>	<b>1.0287</b>	<b>Disorders of the Biliary Tract W CC</b>	<b>2</b>	<b>4%</b>
<b>277</b>	<b>0.8703</b>	<b>Cellulitis Age &gt; 17 W CC</b>	<b>2</b>	<b>4%</b>
<b>321</b>	<b>0.6104</b>	<b>Kidney &amp; Urinary Tract Infections Age &gt; 17 W/O CC</b>	<b>2</b>	<b>4%</b>
395	0.8359	Red Blood Cell Disorders Age > 17	2	4%
087	1.3589	Pulmonary Edema & Respiratory Failure	1	2%
127	1.0302	Heart Failure & Shock	1	2%
138	0.8049	Cardiac Arrhythmia & Conduction Disorders W CC	1	2%
141	0.7149	Syncope & Collapse W CC	1	2%
174	0.9880	G.I. Hemorrhage W CC	1	2%
<b>180</b>	<b>0.9240</b>	<b>G.I. Obstruction W CC</b>	<b>1</b>	<b>2%</b>
204	1.2020	Disorders of Pancreas Except Malignancy	1	2%
242	1.1295	Septic Arthritis	1	2%
316	1.2996	Renal Failure	1	2%
331	1.0122	Other Kidney & Urinary Tract Diagnoses Age > 17 W CC	1	2%
419	0.9223	Fever of Unknown Origin Age > 17 W CC	1	2%
420	0.6258	Fever of Unknown Origin Age > 17 W/O CC	1	2%

<sup>1</sup> The total for this column will not equal 100 percent due to rounding.

<sup>2</sup> W CC represents with complications and comorbidities.

# APPENDIX B

## OFFICE OF INSPECTOR GENERAL'S VALIDATION WORK FOR DRG 416

This table shows the appropriate diagnosis related groups (DRGs) for 17 erroneous DRG 416 discharges. The errors were found by the Office of Inspector General's validation work for DRG 416 (Septicemia Age > 17).

Hospital DRG	DRG Weight	Description	Upcoding Frequency	Percent of Total <sup>1</sup>
<b>320</b>	<b>0.9320</b>	<b>Kidney &amp; Urinary Tract Infections Age &gt; 17 W CC <sup>2</sup></b>	<b>4</b>	<b>24%</b>
<b>089</b>	<b>1.1211</b>	<b>Simple Pneumonia &amp; Pleurisy Age &gt; 17 W CC</b>	<b>2</b>	<b>12%</b>
182	0.7794	Esophagitis, Gastroent & Misc. Digest Disorders Age > 17 W CC	2	12%
073	0.7730	Other Ear, Nose, Mouth & Throat Diagnoses Age > 17	1	6%
<b>180</b>	<b>0.9240</b>	<b>G.I. Obstruction W CC</b>	<b>1</b>	<b>6%</b>
<b>207</b>	<b>1.0287</b>	<b>Disorders of the Biliary Tract W CC</b>	<b>1</b>	<b>6%</b>
272	1.0208	Major Skin Disorders W CC	1	6%
<b>277</b>	<b>0.8703</b>	<b>Cellulitis Age &gt; 17 W CC</b>	<b>1</b>	<b>6%</b>
294	0.7579	Diabetes Age > 35	1	6%
<b>296</b>	<b>0.9166</b>	<b>Nutritional &amp; Misc. Metabolic Disorders Age &gt; 17 W CC</b>	<b>1</b>	<b>6%</b>
297	0.5353	Nutritional & Misc. Metabolic Disorders Age > 17 W/O CC	1	6%
<b>321</b>	<b>0.6104</b>	<b>Kidney &amp; Urinary Tract Infections Age &gt; 17 W/O CC</b>	<b>1</b>	<b>6%</b>

<sup>1</sup> The total for this column will not equal 100 percent due to rounding.

<sup>2</sup> W CC represents with complications and comorbidities.



**APPENDIX C**

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**HEALTH CARE FINANCING ADMINISTRATION COMMENTS**



DATE: FEB 16 1999

TO: June Gibbs Brown  
Inspector General

FROM: Nancy-Ann Min DeParle *NMD*  
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Payments for Septicemia," (OEI-03-98-00370)

We appreciate having the opportunity to review the draft report that examined a sample of diagnosis related group (DRG) 416 cases for inappropriate billing under Medicare's prospective payment system.

We agree with the report's recommendation for greater attention to possible payment errors resulting from coding of discharge diagnoses in a way that incorrectly assigns them to DRG 416. Under the Peer Review Organization (PRO) contracts that will take effect between August 1999 and February 2000, PROs will conduct a Payment Error Prevention Program (PEPP) for inpatient hospital care. It is our plan to have the PROs devote approximately 30 percent of their resources to efforts to reduce payment errors. In particular, the PROs will be required to conduct DRG validation projects during the first year of the contract cycle. The analysis presented by the OIG is representative of the types of analyses that the PROs will be expected to undertake. This will lead PROs to identify in their state DRGs (such as Septicemia) where education of the provider community is warranted. PROs will then create educational initiatives with respect to those DRGs, regarding proper coding, documentation and billing. The goal is to reduce the payment error rate in the future. Where the PROs have confirmed incorrect coding, the appropriate adjustments will be made. The PROs will also be instructed to refer for action providers suspected of fraud or abuse of the Prospective Payment System or providers who fail to respond to educational efforts. Our specific comments follow:

OIG Recommendation

HCFA should institute a system to identify hospitals with atypically high billings for DRGs identified by the Clinical Data Abstraction Centers as having a high potential for being upcoded.

HCFA Response

We concur. Under PEPP, the Health Care Financing Administration (HCFA) will conduct an independent ongoing surveillance of inpatient payment error rates, both nationally and on a state-by-state basis; the surveillance sample will be about twice the size of the current Clinical Data Abstraction Center sample for DRG verification. This sample will be large enough to define the payment error rate at the state level, but will not be large enough to identify specific sources of error in individual providers. HCFA will also conduct analyses of discharge patterns, including analyses similar to those suggested by the report, and will provide the results to PROs. PROs will conduct additional analyses of discharge patterns, and each will take steps that are appropriate to local patterns and circumstances to reduce or eliminate erroneous billing. Each PRO's contract performance will be judged and rewarded according to the reduction in the payment error rate that is achieved in the state over the course of the contract.